

NOV 2 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Missouri
Township Chico
City Nyath (No.)

Registration District No. 5-69
Primary Registration District No. 5-765

File No. 33460
Registered No.
St. Ward

2. FULL NAME

Dilla Tillman
(s) Residence, No. St. Ward.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emmitt Tillman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR 15 - 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 5 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 12 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss

13. NAME DK

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK

15. MAIDEN NAME DK

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK

17. INFORMANT (ADDRESS) Emmitt Tillman

18. BURIAL, CREMATION, OR REMOVAL

PLACE Oak Grove DATE 9/7 1934

19. UNDERTAKER (ADDRESS) Charleston Furn. Co.
Charleston Mo.

20. FILED 7 1934 W. Marshall Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 6 1934

22. I HEREBY CERTIFY, That I attended deceased from 1934, to 19.....

I last saw h..... alive on X, 19..... Death is said to have occurred on the date stated above, at 2 P. m. 2 am

The principal cause of death and related causes of importance were as follows:

had no physician from history of case had Nephritis

Other contributory causes of importance:

Name of operation none Date of
What test confirmed diagnosis? X Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....

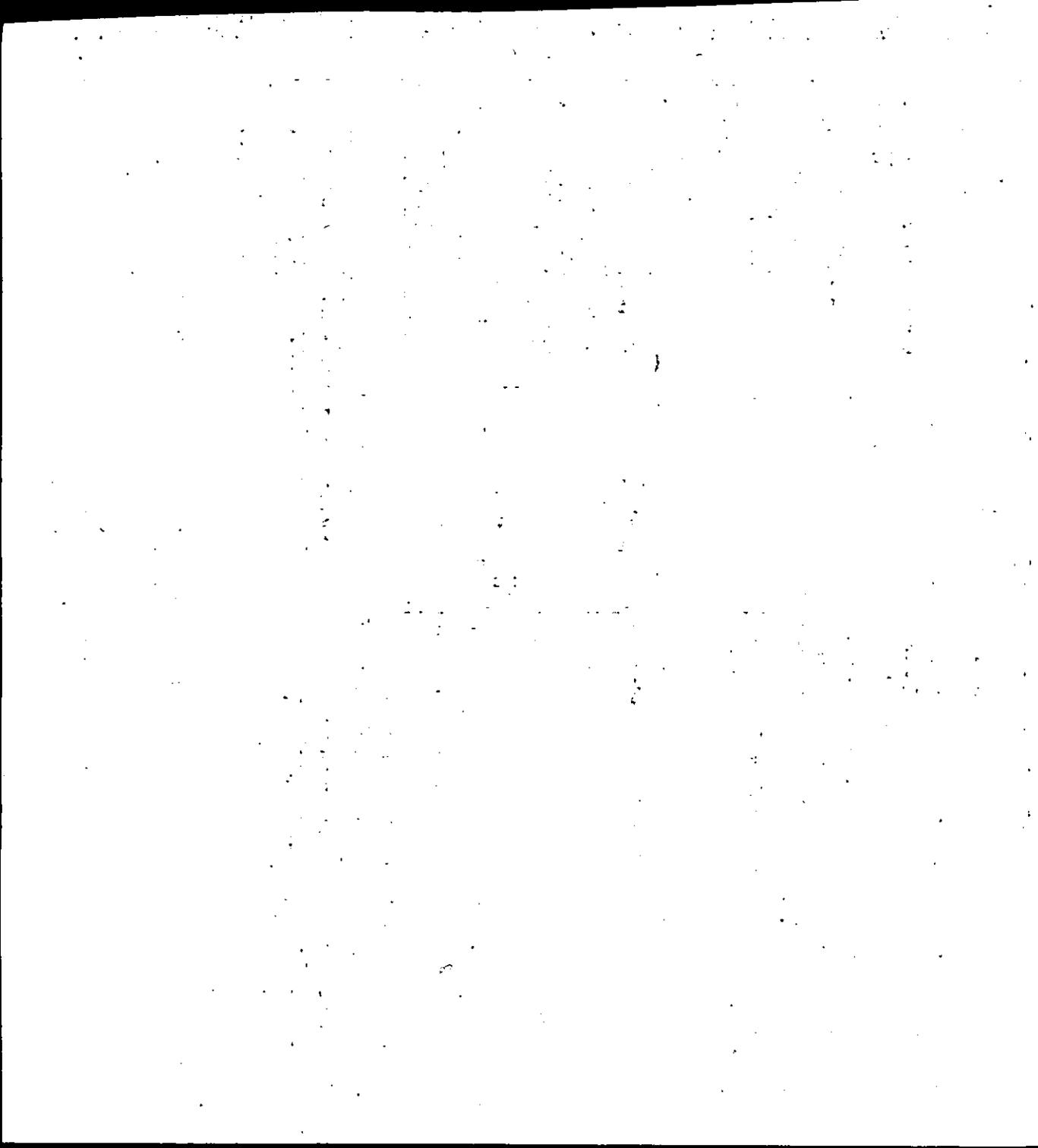
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) W. Marshall, M. D.
(Address) Nyath Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Mississippi

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Willa Johnson*
Who died at _____ on *Sept 6 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: _____ Years _____ Months _____ Days _____
Sex *F* Color or race *B* ~~Single, married, widowed or divorced:~~ _____

Date of birth _____ Age: Years *45* Months *5* Days *22*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: *No physician in attendance - from history of case (repeated)* Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: *Chronic*

Other contributory causes of importance *137*
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician *A. R. Marshall*
Address of physician *Went Mo.*
Signature of Registrar *A. R. Marshall* Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *569* Very truly yours,
Primary Reg. Dist. No. *5765* *E. T. McGaugh*
State Registrar
Special Agent.

1934

S-33460